MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

October 18-19, 2001

Applying quality improvement standards to the Medicare+Choice and the traditional fee-for-service Medicare program

ISSUE: What are appropriate quality improvement standards for Medicare? Should standards comparable to the Medicare+Choice (M+C) quality improvement standards apply to the fee-for-service program? If so, how? Should Medicare apply quality improvement standards differently to different types of M+C plans? If so, how? How should quality improvement data be used?

KEY POINTS: The Center for Medicare and Medicaid Services (CMS), private purchasers, and accreditors are increasingly focused on strategies to stimulate quality improvement activities. This is because of concerns about the well-documented gap between care known to lead to better outcomes and the care patients actually receive. The Balanced Budget Act of 1997 (BBA) M+C quality improvement requirements represent a shift for Medicare from assuring a minimal level of quality for beneficiaries to requiring plans to work continually to improve quality. Recognizing that some health plans may not be as able as others to measure and improve care, Congress exempted non-HMOs from the M+C provisions requiring plans to demonstrate improvement. Although CMS is working to improve quality in ways similar to the M+C program, comparable quality improvement standards are not applied to the fee-for-service Medicare program or to individual providers in the program.

CMS could expect providers and plans to measure, work to improve quality, and demonstrate the results of their efforts on a core set of measures directly, or through required participation in PRO efforts. However, the standards necessary to achieve these goals would need to vary based on the responsibilities and abilities of each type of plan or provider, specifically whether it was possible for them to (1) collect and analyze the necessary data, and (2) improve care. The decision as to whether regulators or the public should have access to the information generated by these standards to compare plans or providers depends on the validity of the data.

ACTION: The Commission should provide comments on the outline for the report and potential recommendations. The three background papers provide an overview and analysis of (1) current practices and future trends in quality improvement, (2) the M+C quality improvement requirements, and (3) the fee-for-service program quality improvement efforts. The chart is designed to assist you in considering the policy options. The Commission may want to discuss specific policy options for each type of plan or provider listed in the chart – HMOs, non-HMOs, the fee-for-service program as a plan, organizational providers and clinicians.

This report is due to the Congress December 1, 2001.

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